

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/16/2024
NAME OF PROVIDER OR SUPPLIER  Ocean Ridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3850 E. Esther St. Long Beach, CA 90804	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46537</p> <p>Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for one of three sampled residents (Resident 1) by failing to:</p> <p>A. Ensure Certified Nurse Assistant (CNA) 1 answered Resident 1s' call light in a timely manner.</p> <p>B. Ensure CNA 2 answered Resident 1's call light and provided hygiene care with adult briefs change in a timely manner.</p> <p>This failure has potential to result in Resident 1 feeling ignored and like he did not matter, and placed Resident 1 at risk for skin breakdown due to sitting in soiled adult brief for a long period of time.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the Admission Record indicated, Resident 1 was initially admitted to the facility on [DATE] and last re-admission was on 5/7/2024 with diagnoses including generalized muscle weakness, benign neoplasm of meninges (a tumor that grows from the membranes that surround the brain and spinal cord, called the meninges), and lack of coordination.</p> <p>During a review of Resident 1 ' s Psychiatry (medical specialty in mental health diagnosis and treatment) Nurse Practitioner Notes (PNPN), dated 3/28/2024, the PNPN indicated, Resident 1 had the capacity to consent.</p> <p>During a review of Resident 1 ' s Minimum Data Set ([MDS]-a standardized assessment and care screening tool), dated 6/7/2024, the MDS indicated Resident 1 required dependent assistance (Helper does all of the effort) from two or more staff for toileting hygiene, shower/bathe self, and maximal assistance (Helper does more than half the effort) from one staff for roll left and right, chair/bed to chair transfer.</p> <p>A. During an observation on 9/11/2024, at 10:47 a.m., in Resident 1 ' s room, Resident 1 pressed the call light to let nursing staff know about a broken window screen in his room.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 9/11/2024, at 10:54 a.m., in Resident 1 ' s room, CNA 1 came in to attend to Resident 3 (Resident 1 ' s roommate) who waved his hands to CNA 1. CNA 1 did not check on Resident 1 and left the room to speak to another staff outside of the room.</p> <p>During an observation on 9/11/2024, at 11:00 a.m., in Resident 1 ' s room, Family Member (FM) 1 called CNA 1 and asked CNA 1 to come in. CNA 1 stated, she did not realize Resident 1 ' s call light was on when FM 1 questioned the reason why she did not answer the call light.</p> <p>During an interview on 9/11/2024, at 11:03 a.m., in Resident 1 ' s room, FM 1 stated, Resident 1 and her felt like CNA 1 was ignoring the call light intentionally because of a previous grievance (a formal complaint or concern) she filed against a few CNAs as retaliation (any act of harm committed in response to an actual oerceived harm). FM 1 stated, there was another incident that happened with CNA 2 on 9/10/2024 when she arrived at the facility at 8:30 a.m. on 9/10/2024 and found out Resident 1 ' s diaper was soaking wet, and feces leaked from his diaper to his absorbent bed pad. FM 1 stated, she pressed call light at 8:45 a.m. and asked Licensed Vocational Nurse (LVN)1 and Registered Nurse Supervisor (RNS) 1 to change Resident 1. FM 1 stated, CNA 2 came in at 9:30 a.m. to change Resident 1 and refused to shower Resident 1 until after the lunch. FM 1 stated, Resident 1 was sitting in soiled adult briefs for an hour and his needs were being ignored.</p> <p>During an interview on 9/11/2024, at 2:36 p.m., with CNA 1, CNA 1 stated, she saw Resident 3 was waving his hands and she came in the room. CNA 1 stated, she did not check on Resident 1 because she did not realize his call light was on. CNA 1 stated, she should have checked on him since she was already in the room. CNA 1 stated, she should have paid more attention to the call light. CNA 1 stated, Resident 1 might feel ignored, and the care would be delayed if the call light was not answered in timely manner.</p> <p>B. During an interview on 9/12/2024, at 9:00 a.m., with Resident 1, Resident 1 stated, he was having issues with CNAs not answering his call light. Resident 1 stated, the Director of Nursing (DON) placed the sign above the call light not to turn off the call light until requests were met. Resident 1 stated, he did not appreciate being ignored, and that sitting in a soiled diaper made him feel worthless.</p> <p>During a concurrent interview and record review on 9/12/2024, at 9:18 a.m., with the Director of Staff Development (DSD), CNA 2 ' s record of One-on-One Coaching, dated 12/14/2023 was reviewed. The One-on-One Coaching Record indicated, the DSD spoke to CNA 2 regarding tending to the residents needs and the importance of providing incontinent care in a timely manner. The DSD stated, she should have provided frequent in-services (staff education) and monitored compliance.</p> <p>During a concurrent interview and record review on 9/12/2024, at 9:40 a.m., with the DSD, CNA 1 ' s One-on-One Coaching Record, undated was reviewed. The One-on-One Coaching Record indicated, the DSD spoke to CNA 1 regarding answering the call light in a timely manner and tending to the residents ' needs as soon as she could. The DSD stated, CNA 1 had a previous incident, and she should have provided in-services more frequently.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/12/2024, at 11:58 a.m., with CNA 2, CNA 2 stated, she answered the call light for Resident 1, but she did not change him right away because she was not sure if she was assigned to Resident 1. CNA 2 stated, there were schedule changes and she realized she was assigned to Resident 1. CNA 2 stated, she should have changed him right away or taken him to shower as FM 1 requested.</p> <p>During an interview on 9/12/2024, at 5:30 p.m., with the DON, the DON stated, all nursing staff should answer the call light as soon as possible and provide hygiene care regardless of patient assignment. The DON stated, the facility should monitor and educate CNA 1 and CNA 2 frequently to prevent repeated incidents. The DON stated, all residents should be treated respectfully and provided with the care they needed. The DON stated, Resident 1 could suffer from skin breakdown and infection if soiled adult briefs were not changed for long period of time.</p> <p>During a review of Resident 1 ' s Care Plan (CP), revised on 5/8/2024, the CP Focus indicated, Resident 1 was at risk for Activity of Daily Living (ADL- toileting, hygiene, getting dressed) decline. The CP Goal indicated, Will have needs anticipated and met by staff. The CP Interventions indicated, to encourage to use call light for assistance.</p> <p>During a review of Resident 1 ' s CP, revised on 5/8/2024, the CP Focus indicated, Resident 1 was at risk for skin breakdown. The CP Goal indicated, Will prevent or delay skin breakdown to the extent possible given risk factors. The CP Interventions indicated, keep skin clean and dry to the extent possible.</p> <p>During a review of the facility ' s Policy and Procedure (P&amp;P) titled, Activities of Daily Living (ADL), Supporting, revised 3/2018, the P&amp;P indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care) . c. elimination (toileting).</p> <p>During a review of the facility ' s Policy and Procedure (P&amp;P) titled, Answering the Call Light, revised 9/2022, the P&amp;P indicated, Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs .Steps in the Procedure: 1. Answer the resident call system immediately. a. If the resident needs assistance, indicate the approximate time it will take for you to respond .c. If the resident's request is something you can fulfill, complete the task within five minutes if possible.</p> <p>During a review of the facility ' s Policy and Procedure (P&amp;P) titled, Job Description: Certified Nursing Assistant (CNA), dated 2/2019, the P&amp;P indicated, Essential Duties . Answer resident calls promptly. Check residents routinely to ensure that their personal care needs are being met . Keep residents dry (change gown, clothing and linens, when it becomes wet or soiled) . Check each resident routinely to ensure that his/her personal care needs are being met in accordance with his/her wishes.</p>		